Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: MM5036 Revised	**Related Change Request (CR) #: 5036 and 4183**
Related CR Release Date: March 24, 2006	**Effective Date: April 1, 2006**
Related CR Transmittal #: R43DEMO	**Implementation Date: April 3, 2006**

Note: This article was revised on March 30, 2006, to show that the implementation date is April 3, 2006, as shown in CR5036. Several Physician Voluntary Reporting Program (PVRP) performance measure CPT codes in CR4183 have been modified as a result of additional input received by CMS from medical specialty societies. In addition, CPT Category II codes are now available for certain measures. The changes are reflected in CR5036 and, if you are viewing a color print of this article, are highlighted yellow. This article contains the same information as MLN Matters article MM4183 with the following additions:

- The code changes and the addition of Category II CPT codes in the attachments.
- An "Introduction" section that helps physicians understand who can report and the benefits of registering their intent to participate in the program.
- Announcement of a web site address that contains additional information on the PVRP. This web address is **http://www.cms.hhs.gov/PVRP**. Also, in the "Additional Information" section of this article is a note about some helpful worksheets that will be placed on this site in the near future.

Physician Voluntary Reporting Program (PVRP) Using Quality G-Codes and CPT Category II Codes (CPT II Codes).

Provider Types Affected

Physicians

Introduction

In January of 2006, the Centers for Medicare and Medicaid Services (CMS) launched the PVRP with a core starter set of 16 measures. Collection of data on the 16 measures is currently underway.

Physicians can report on the PVRP measures regardless of whether or not they register their intent to participate. **However, CMS is strongly encouraging physicians to register their intent to participate in the PVRP through the secured link http://www.qualitynet.org.** By registering their intent to participate, physicians will be able to receive confidential feedback on their reporting rate and performance rate for each measure they report on. Registering the intent to participate is the first step to receiving the confidential feedback

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report. In June, CMS will begin contacting those who register their intent to participate to walk them through finishing the confidential registration process. By registering the intent to participate now, physicians not only have the ultimate benefit of receiving feedback reports on the PVRP measures, but will also have CMS assistance in completing the full registration for the feedback reports.

Registration of intent to participate does not obligate a physician to participate. CMS understands that unpredictable events may occur that would ultimately prevent one from actually participating. Also, as stated earlier, physicians can submit data on the PVRP measures without registering their intent to participate.

CMS encourages physicians to register their intent to participate by April 1, 2006. The first physician feedback reports will be available in December 2006. Reports will be based on second quarter data, collected from claims data with dates of service between April 1 and June 30. Although registration of intent to participate will be welcomed after April 1, CMS encourages physicians to register their intent by April 1 so that comprehensive feedback reports reflect as much data collected in the second quarter as possible. Again, physicians can continue to submit data on PVRP measures whether they register their intent or not.

Provider Action Needed

This article provides information about the CMS PVRP. It will assist physicians in understanding this new voluntary reporting program and the use of G-codes or newly added CPT II codes to report data about the quality of care provided to Medicare beneficiaries.

Background

As part of its overall quality improvement efforts, CMS launched the PVRP in January 2006. This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered.

Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP began in January 2006.

National Consensus Measures and Indicators

CMS has begun the process of developing a comprehensive set of national consensus measures and indicators that will allow physicians to more efficiently

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report quality information on the health services provided to Medicare beneficiaries.

CMS identified 36 evidence-based clinically valid measures that have been part of the guidelines endorsed by physicians and medical specialty societies. The 36 measures are the result of extensive input and feedback from physicians and other quality care experts.

However, after announcing the PVRP on October 28, 2005, suggestions were made by several physician organizations to identify a starter set in order to lessen the potential reporting burden for physicians and better align the PVRP with other quality measurement activities affecting physicians.

CMS decided to adopt the suggestion of a smaller core starter set of PVRP measures. The core set consists of 16 measures, which will significantly reduce the number of measures applicable to any individual physician practice specialty. Despite the reduction to a core starter set of 16 measures, the PVRP maintains the same scope of coverage for physician specialties. Additional measures to cover a broader set of specialties will be developed in the future.

CMS has selected measures based on the work of the National Quality Forum (NQF) and the Ambulatory Care Quality Alliance (AQA).

Confidential feedback reports available to physicians will be limited to the 16 core starter set. The confidential feedback reports will provide physicians with information about their performance and reporting rates for measures associated with submitted data. The feedback reports are intended to assist physicians in improving their data accuracy and reporting rate. The first feedback report will be available December 2006 and will reflect data submitted during the second quarter (April 1 – June 30).

Data Collection Through the Administrative Claims System

The usual source of the clinical data for quality measures is retrospective chart abstraction, but data collection through chart abstraction can be quite burdensome. In addition, while electronic health records (EHRs) may greatly facilitate clinical data reporting in the future, most physicians currently are not using an EHR.

Therefore, to avoid the necessity for chart abstraction, CMS is beginning the process of collecting quality information on services provided to the Medicare population by using the administrative claims system.

Use of G-Codes and CPT II Codes

Specifically, CMS has defined a set of HCPCS codes to report data for the calculation of the quality measures. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

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Each measure has a defined numerator (the appropriate G-code or CPT II code) and a denominator (specifically defined according to the appropriate services or condition). The reporting rate is calculated as a percentage for each of the 16 measures.

You can use G-codes or CPT II codes when all of the following circumstances are met:

- The G-code or CPT II code reported on the claim relates to a covered diagnosis, covered treatment(s), or covered preventive service(s) that are applicable to the beneficiary.
- The basis for the G-code or CPT II code is documented in the beneficiary medical record.

Note: Submit either a G-code **or** a CPT II code, but never both.

Important Points: PVRP Reporting on Medicare Claims

G-codes or CPT II codes:

- Are submitted on the Medicare claim form generated after a covered service has been performed.
- Should be reported with a submitted charge of zero ($0.00).
- Are not specialty specific. However, it is anticipated that the reporting of certain G-codes or CPT II codes will be predominated by physicians in certain specialties.

Additional Information

The specific quality measures related to the G-codes or CPT II codes in this initial program launch are reflected in the table at the end of this article.

You can find more information about the PVRP and quality G-Codes and CPT II codes in CR 5036. CR5036 is available at **http://www.cms.hhs.gov/Transmittals/downloads/R43DEMO.pdf** on the CMS web site. CR4183 is also available at **http://www.cms.hhs.gov/Transmittals/downloads/R35DEMO.pdf** on the CMS web site.

Additional information about the program is available at **http://www.cms.hhs.gov/PVRP** on the CMS site. You may want to visit this site periodically for updates. CMS will soon post the one-page worksheets developed specifically for certain specialties to assist in reporting relevant information to the PVRP.

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Finally, if you have any questions, please contact your Medicare carrier at their toll-free number, which may be found at **http://www.cms.hhs.gov/apps/contacts/** on the CMS web site.

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Physician Voluntary Reporting Program
G-Codes and CPT II Codes and Descriptions for Clinical Measures
Effective April 1, 2006

Measure	G-Code/Descriptions
Aspirin at arrival for acute myocardial infarction	●**G8006**: Acute myocardial infarction: patient documented to have received aspirin at arrival ●**G8007**: Acute myocardial infarction: patient not documented to have received aspirin at arrival ●**G8008**: Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure
Beta blocker at time of arrival for acute myocardial infarction	●**G8009**: Acute myocardial infarction: patient documented to have received beta-blocker at arrival **OR CPT Cat II code 4006F:** Beta-blocker therapy prescribed ●**G8010**: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival ●**G8011**: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure **OR CPT Cat II code 4006F WITH modifier 1P, 2P, or 3P:** Beta-blocker therapy prescribed with exclusion
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus	●**G8015**: Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented as greater than 9% **OR CPT Cat II code 3046F:** Most recent hemoglobin A1c level > 9.0% ●**G8016**: Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented as less than or equal to 9% **OR CPT Cat II code 3047F:** Most recent hemoglobin A1c level ≤ 9.0% ●G8017: Clinician documented that diabetic patient was not an eligible candidate for hemoglobin A1c measure **OR CPT Cat II code 3046F WITH modifier 1P, 2P, or 3P**: Most recent hemoglobin A1c level > 9.0% with exclusion ●**G8018**: Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (12 months)
Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus	●**G8020**: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl **OR CPT Cat II code 3048F:** Most recent LDL-C < 100 mg/dL ●**G8019**: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl **OR CPT Cat II code 3049F:** Most recent LDL-C 100-129 mg/dL **OR CPT Cat II code 3050F:** Most recent LDL-C ≥ 130 mg/dL ●**G8021**: Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure **OR CPT Cat II code 3048F WITH modifier 1P, 2P, or 3P:** Most recent LDL-C < 100 mg/dL with exclusion ●**G8022**: Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)
High blood pressure control in patient with Type I or Type II diabetes mellitus	●**G8024**: Diabetic patient with most recent blood pressure (within the last 12 months) documented less than 140 systolic and less than 80 diastolic **OR CPT Cat II code 3076F:** Most recent systolic blood pressure < 140 mm Hg **AND CPT Cat II code 3078F:** Most recent diastolic blood pressure < 80 mm Hg ●**G8023**: Diabetic patient with most recent blood pressure (within the last 12 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic **OR CPT Cat II code 3077F:** Most recent systolic blood pressure ≥ 140 mm Hg **AND CPT Cat II code 3079F:** Most recent diastolic blood pressure 80-89 mm Hg **OR CPT Cat II code 3077F:** Most recent systolic blood pressure ≥ 140 mm Hg **AND CPT Cat II code 3080F:** Most recent diastolic blood pressure ≥ 90 mm Hg ●G8025: Clinician documented that the diabetic patient was not an eligible candidate for blood pressure measure **OR CPT Cat II code 3076F WITH modifier 1P, 2P, or 3P**: Most recent systolic blood pressure < 140 mm Hg with exclusion **AND CPT Cat II code 3078F WITH modifier 1P, 2P, or 3P:** Most recent diastolic

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Measure	G-Code/Descriptions
	blood pressure < 80 mm Hg with exclusion ●**G8026**: Clinician has not provided care for the diabetic patient for the required time for blood pressure measure (within the last 12 months)
Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction	●**G8027**: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy **OR CPT Cat II code 4009F:** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed ●**G8028**: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy ●**G8029**: Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure **OR CPT Cat II code 4009F WITH modifier 1P, 2P, or 3P:** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed with exclusion
Beta-blocker therapy for patient with prior myocardial infarction	●**G8033**: Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy **OR CPT Cat II code 4006F:** Beta-blocker therapy prescribed ●**G8034**: Prior myocardial infarction - coronary artery disease patient not documented to be on beta -blocker therapy ●**G8035**: Clinician documented that prior myocardial infarction - coronary artery disease patient was not an eligible candidate for beta - blocker therapy measure or the patient had no prior myocardial infarction **OR CPT Cat II code 4006F WITH modifier 1P, 2P, or 3P:** Beta-blocker therapy prescribed with exclusion
Assessment of elderly patients for falls	●**G8055**: Patient documented for the assessment for falls within last 12 months ●**G8054**: Patient not documented for the assessment for falls within last 12 months ●**G8056**: Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months
Dialysis dose in end stage renal disease patient	●**G8075**: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2) ●**G8076**: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2) ●**G8077**: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure
Hematocrit level in end stage renal disease patient	●**G8078**: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11) ●**G8079**: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11) ●**G8080**: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure
Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis	●**G8081**: End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula ●**G8082**: End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula ●**G8085:** End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula
Antidepressant medication	●**G8126**: Patient documented as being treated with antidepressant medication during the entire 12 week

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Measure	G-Code/Descriptions
during acute phase for patient diagnosed with new episode of major depression	acute treatment phase ●**G8127**: Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase ●**G8128**: Patient was not treated with antidepressant medication or was not an eligible candidate for completion of the entire 12 week acute treatment phase
Antibiotic prophylaxis in surgical patient	●**G8152**: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin and fluoroquinolone) ●**G8153**: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin and fluoroquinolone) ●**G8154**: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin and fluoroquinolone) measure
Thromboembolism prophylaxis in surgical patient	●**G8155**: Patient with documented receipt of thromboemoblism prophylaxis ●**G8156**: Patient without documented receipt of thromboemoblism prophylaxis ●**G8157**: Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure
Use of internal mammary artery in coronary artery bypass graft surgery	●**G8158**: Patient documented to have received coronary artery bypass graft with use of internal mammary artery ●**G8159**: Patient documented to have received coronary artery bypass graft without use of internal mammary artery ●**G8160**: Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure
Pre-operative beta blocker for patient with isolated coronary artery bypass graft	●**G8161**: Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade **OR CPT Cat II code 4006F:** Beta-blocker therapy prescribed ●**G8162**: Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade ●**G8163**: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure **OR CPT Cat II code 4006F WITH modifier 1P, 2P, or 3P:** Beta-blocker therapy prescribed with exclusion

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